U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 24 June 2005

Case No.: 2004-BLA-05497

In the Matter of

BETTY L. FIELDS, Widow of
BILLY FIELDS
Claimant

v.

ISLAND CREEK COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Leonard Stayton, Esquire
For Claimant

Mary Rich Maloy, Esquire
For Employer

Before: JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER
DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

[1] The regulations cited are the amended regulations that became effective on January 19, 2001. 20 C.F.R. § 718, et. seq. (2001).

On December 30, 2003, this case was referred to the Office of Administrative Law Judges for a formal hearing. DX 34.[2] It was assigned to me on April 12, 2004. The hearing was held before me in Charleston, West Virginia, on August 31, 2004, where the parties had full opportunity to present evidence and argument. At the hearing evidence marked as DX 1 – 37, EX 1 – 6 and portions of EX 8 and EX 9 were received into evidence.[3] Claimant was granted additional time to submit the report of Dr. Joshua Perper. Tr. at 6-7. Claimant submitted Dr. Perper's report and curriculum vitae on November 29, 2004. These records are herewith received into evidence as CX 1 and CX 2, respectively. Employer was also granted additional time to submit rehabilitative or rebuttal evidence. Tr. at 6-7. Employer submitted supplemental reports by Dr. Stephen Bush (EX 11) and Dr. Gregory Fino (EX 12), and the deposition testimony of Dr. Kirk Hippensteel (EX 13) and Dr. Bush (EX 14) on February 24, 2005. These records are herewith received into evidence. Claimant filed a brief on April 11, 2005. Employer filed a brief on April 15, 2005. The decision that follows is based on a thorough review and analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

Claimant and Employer stipulated to a coal mine employment history of 43 years. Employer also conceded that it was the responsible operator, Claimant was the miner's dependent, and that pneumoconiosis arising out of coal mine employment had been established. Tr. at 29. I find that the record supports these stipulations.

The only issue presented for adjudication is whether the miner's death was due to pneumoconiosis.

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Billy Fields (or "the miner") filed for living miner's benefits on May 16, 1973. The District Director denied benefits on October 25, 1973, finding that the miner had not established any of the elements to entitlement. The Director again denied entitlement under the Act on April 18, 1980. DX 1. The miner filed for living miner's benefits again on January 23, 1995. The District Director denied benefits in an undated letter, finding the miner had not established any of the elements to entitlement. DX 2.

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[2] The following abbreviations are used herein: "CX" refers to Claimant's Exhibits; "DX" refers to Director's Exhibits; "EX" refers to Employer's Exhibits; and "Tr." refers to the transcript of the August 31, 2004 hearing.

[3] The following Employer's Exhibits were rejected at the hearing for exceeding the evidentiary limitations imposed pursuant to § 725.414: Dr. Naeye's report (EX 7), X-ray reports by Drs. Meyer and Wiot (EX 8), Dr. Spitz's reading of the miner's February 21, 1995 X-ray and pulmonary function test results dated April 10, 1985 (EX 9), and Dr. Spagnolo's report (EX 10). Tr. at 24 – 28.

The miner died on February 1, 2003, and Claimant filed the instant claim for survivor's benefits on March 11, 2003. DX 4. The District Director denied benefits on October 29, 2003, finding that Claimant had not established that the miner's death was due to pneumoconiosis. DX 28. On November 5, 2003, Claimant requested a formal hearing. DX 30.

B. Factual Background

The miner was born on February 3, 1932. DX 4. The miner married Claimant on April 19, 1957. The miner also has a child, Amber Fields who was born on January 15, 1986, and was a full time student in high school at the time of the hearing. Tr. at 17; DX 12, 13. Both Claimant and Amber qualify as the miner's dependents for purposes of entitlement to survivor's benefits under the Act.

Claimant testified that the miner's breathing deteriorated to the point that he was prescribed nebulizers. The miner used the medication more frequently than the prescribed usage of every four hours because of his difficulty breathing. Tr. at 21. Claimant testified that shortly before her husband's death, he had completely lost his appetite, was not eating at all, and was having trouble breathing. Tr. at 22. She also stated that the miner had been diagnosed with a heart problem three or four years before his death that was treated only with medication. Tr. at 20. On September 1, 2002, the miner was diagnosed with lymphoma, which was treated through chemotherapy. Tr. at 20. Claimant also clarified that the miner's smoking history did not consist of smoking cigars but chewing them. Tr. at 19.

C. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. § 718.2. Section 718.205(a) provides that in order to establish entitlement to survivor's benefits under Part 718, Claimant must prove that the miner had pneumoconiosis, that it arose out of his coal mine employment, and that the miner's death was due to pneumoconiosis. Claimant has the burden of establishing each element of entitlement by a preponderance of the evidence. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

D. Relevant Medical Evidence of Record

The miner treated with Dr. Ramakrishman S. Iyer from November 12, 1991 until January 14, 2003. The miner first visited Dr. Iyer after being referred for a cardiac evaluation. During the visit, the miner denied chest pain, dyspnea, palpitations, or syncope. The physician recorded that the miner had a history of hypertension and black lung. On physical examination, Dr. Iyer noted a short ejection systolic murmur in the aortic area. The physician also noted that an echocardiogram showed "concentric left ventricular hypertrophy with LVOT obstruction. . ." and an electrocardiogram showed "right bundle branch block and left anterior hemiblock." Of note, on the miner's November 25, 1991 visit, Dr. Iyer found that the miner's echocardiogram showed idiopathic hypertrophic phlebotic stenosis and physical examination of the miner showed an asystolic murmur in the left sternum border. Also, on May 6, 1997, the physician noted that the miner's echocardiogram "was consistent with hypertrophic obstruction..." DX 16.

Contained in the records of Dr. Narcisco Tuanquin is an arterial blood gas study performed on February 8, 2000. The results showed the miner had a pCO_2 of 31.7 and a pO_2 of 99.7. DX 17.

Dr. Iyer performed an echocardiogram on the miner on June 29, 2000, and issued a report on that date. The physician's "[f]indings [we]re consistent with hypertrophic sub-aortic stenosis with outflow tract obstruction. Heavy mitral annular calcification. Aortic valve scerosis. Mild to moderate aortic regurgitation. Mild mitral and tricuspid regurgitation with mild pulmonary hypertension." DX 16.

Dr. Iyer saw the miner on July 1 and 12, 2001, and noted a systolic murmur on physical examination on both visits. On July 1, Dr. Iyer found the miner to be "very stable," other than the noted murmur. The physician also noted that the miner had no worsening of his dyspnea and no angina. On July 12, Dr. Iyer ordered a repeat echocardiogram to make sure that the miner's aortic regurgitation was not getting worse and to assess ventricular function. DX 16.

Dr. Iyer performed an echocardiogram on the miner on July 16, 2001, and issued a report on the same day. The physician concluded that the miner had "severe left ventricular hypertrophy with asymmetric septal hypertrophy with significant outflow tract obstruction. There is a mild to moderate aortic and mild mitral regurgitation. There is heavy mitral annular calcification and aortic valve sclerosis." DX 16.

The miner was admitted to Logan General Hospital on August 27, 2002, for abdominal pain. Dr. Jodi M. Cisco documented the miner's medical history and the findings of a physical examination in a report dated August 28, 2002. Dr. Cisco reported that the miner had initially presented to her office on August 19, 2002, was diagnosed with a hernia, and outpatient elective surgery was planned. However, on the day the surgery was scheduled, the miner reported having severe abdominal pain, nausea, and frequent chills and sweats. The physician noted that the miner denied chest pain or palpitation and that a previous cardiac workup was negative. Dr. Cisco also noted that the miner denied cough or shortness of breath and that on physical examination his chest was clear bilaterally and his heart had a regular rate and rhythm. On physical examination of the miner's abdomen, the physician found a "fullness and/or mass present in right abdomen, located in the right mid and upper abdomen and seems to cross to approximately midline." Dr. Cisco cancelled the elective surgery and admitted the miner to manage his pain. EX 2.

The miner was admitted to Logan General Hospital on September 9, 2002, to undergo chemotherapy. Dr. Safique Ahmed examined the miner and in his report of September 9, 2002 noted that the miner had a significant history for non-Hodgkin's lymphoma that was diagnosed one week before. Dr. Ahmed also noted that a CT scan of the miner's abdomen showed a mass on the right side and that a CT guided biopsy showed lymphoma. EX 2.

The miner saw Dr. Iyer on September 10, 2002. The physician diagnosed idiopathic hypertrophic phlebotic stenosis with mitral regurgitation, some degree of aortic regurgitation, and a loud murmur of hearty regurgitation. DX 16. Dr. Iyer performed an echocardiogram on the miner on September 12, 2002, and issued a report on that date, concluding that the miner had

"1. Left ventricular hypertrophy with asymmetric septal hypertrophy with possible outflow tract obstruction[;] 2. Moderate mitral regurgitation and moderate to moderately severe aortic regurgitation[;] 3. Moderate tricuspid regurgitation with mild pulmonary hypertension." DX 16.

The miner was admitted to Logan General Hospital on October 11, 2002, for severe hydration, anemia, neutropenia and hypotension. Dr. Ahmed examined the miner and documented his non-Hodgkin's lymphoma and noted that a second cycle of chemotherapy had been completed on October 2, 2002. Dr. Ahmed reported that the miner was unable to stand, was very weak and anorexic as he had had no appetite for the past few days. The physician concluded that the dehydration, anemia, neutropenia, and hypotension were secondary to the chemotherapy and that the miner's "non-Hodgkin's lymphoma with large mass in the abdomen" had disappeared after the second cycle of chemotherapy. EX 2.

The miner saw Dr. Iyer on November 12, 2002. The physician noted that the miner was receiving chemotherapy and had experienced shortness of breath, weight loss, and episodes of hypotension. Dr. Iyer noted that a recent echocardiogram showed "LHV with evidence of IHSS." Dr. Iyer also noted that the miner had mitral and aortic regurgitation and moderate tricuspid regurgitation with pulmonary hypertention. The physician stated that if the miner's lymphoma is cured he would consider cardiac catheterization and possible surgery to treat the miner's cardiac condition. DX 16.

Dr. Iyer performed an echocardiogram on the miner on November 14, 2002, and issued a report on the same day. The physician concluded that the miner had "asymmetric septal hypertrophy with systolic anterior motion. However, no significant gradient could be demonstrated across the outflow tract. There appears to be mild mitral, aortic and tricuspid regurgitation." DX 16.

The miner was admitted to Logan General Hospital on November 28, 2002, for general body malaise, chills and shortness of breath. Dr. Tuanquin examined the miner and issued a report dated November 29, 2002. The physician noted that the miner had completed three courses of chemotherapy, the last of which was four weeks before his examination. Dr. Tuanquin also noted that the miner had been in his "usual state of health" until he developed an acute onset of chills, general body malaise, and progressive shortness of breath on the day of admission to the hospital. The miner was evaluated in the emergency room where it was found he was clinically dehydrated with evidence of metabolic acidosis. A chest X-ray taken in the emergency room also showed bibasilar infiltrates. The miner denied chest pain, palpitation, orthopnea and leg edema but admitted to chronic exertional dyspnea and an episode of epistaxis several days prior that was controlled through nasal packing. On physical examination, Dr. Tuanquin's found the miner's heart was regular in rate and rhythm and was also positive for a Grade II-III/VI pansystolic murmur at the lower left sternal border with right upper sternal border. The physician also found that the miner's lungs had diminished breath sounds bilaterally with prolonged expiratory phase with crepitant rales at the bases. Dr. Tuanquin also noted that an electrocardiogram showed the miner had sinus tachycardia with occasional suraventricular premature beats and right bundle branch block pattern and non-specific ST-T changes. An arterial blood gas was also performed which showed a pCO2 of 22.4, pO2 of 121.7, and an oxygen saturation level of 98.7. Dr. Tuanquin listed his impression of the miner's condition as

bibasilar pneumonia, non-Hodgkins lymphoma status post chemotherapy four weeks ago, hypertension, anemia, dehydration, and valvular heart disease. EX 2.

On December 2, 2002, the miner had an MRI and Dr. Narcisco Tuanquin issued a radiology report interpreting the results. Dr. Tuanquin found that the miner had a normal sized heart, a tortuous aorta, and minimal bibasal subsegmental atelectatic changes with a small right pleural effusion. DX. 17.

The miner had a CT scan performed on January 9, 2003, and Dr. S.N. Subramaniam issued a radiology report on January 10, 2003. The physician compared this scan to one performed on September 2. Dr. Subramaniam found "small bilateral pleural effusions with bibasal subseqmental atelectatic changes. There is no hilar or mediastinal lymphadenopathy identified. There is no discrete intrapulmonary mass or nodule noted. The previously noted large abdominal mass appears to have almost totally resolved with a minimal residual amount of tumor. There is no fluid noted." EX 2.

The miner presented to Logan General Hospital's Ambulatory-Patient Clinic on January 6, 2003, with complaints of weakness. The miner denied chest pain but admitted that he was not eating enough. The assessment of the miner's condition listed stage IV lymphoma. The plan for the miner's condition was to hold chemotherapy and to check the CT scan from the third week of January 2002. EX 2.

Dr. Iyer last saw the miner on January 14, 2003. The physician noted that the miner was "doing fairly well from a cardiac standpoint but just feels weak and tired." Dr. Iyer also noted that the miner's echocardiogram continued to show mild mitral and aortic and tricuspid regurgitation, but that his left ventricular systolic function was "okay." DX 16.

The miner presented to Logan General Hospital's Ambulatory-Patient Clinic two more times before his death. On January 16, 2003, the miner presented to the clinic without any specific complaints but still had a loss of appetite. The assessment of his condition noted his lymphoma that was status post four cycles of chemotherapy to which he had a good response and his loss of weight and appetite. On January 20, 2003, the miner presented to the clinic complaining of aching in his legs and shoulders. The miner denied shortness of breath or chest pain but admitted to being very weak and still having a poor appetite. The assessment of the miner's condition was listed as malignant lymphoma in stage 4, loss of appetite, and a decrease in "DNC." EX 2.

The miner's death certificate states that the miner died on February 1, 2003, due to cardiorespiratory failure and non-Hodgkin's lymphoma. Malnutrition was also listed an "other significant condition." The certificate was completed by Dr. Safique Ahmed and filed on February 26, 2003. DX 14.

Although the presence of pneumoconiosis has already been stipulated, Employer submitted negative readings of the miner's March 13, 1995 chest X-ray by Drs. Wiot, Meyer, and Spitz, and a report reviewing the miner's January 9, 2004 CT scan by Dr. Wiot in which he opines that there is no evidence of coal workers' pneumoconiosis. (EX 4; 6; 8) Additionally, the

Employer submitted the miner's two pulmonary function tests done in January 6, 1994, and February 21, 1995. The January 6, 1994 pulmonary function test showed an FEV1 of 3.84, an FVC of 4.59, and an FEV1/FVC ratio of 84%. EX 9. The February 21, 1995 pulmonary function test showed an FEV1 of 4.63, an FVC of 5.91, an MVV of 174, and an FEV1/FVC ratio of 78%.[4] EX 1.

E. Elements of Entitlement

1. Presence of Pneumoconiosis

The parties stipulated that the miner had pneumoconiosis. Tr. at 29. I find that the evidence supports this stipulation. Consequently, Claimant has established this element of entitlement.

2. Pneumoconiosis Arising Out of Coal Mine Employment

The parties stipulated that the miner's pneumoconiosis arose out of his coal mine employment. Tr. at 29. I find that the evidence supports this stipulation. Consequently, Claimant has established this element of entitlement.

3. Death Due to Pneumoconiosis

As this survivor's claim was filed after January 1, 1982, under § 718.1 Claimant must show that the miner's death was due to pneumoconiosis. Death due to pneumoconiosis may be established under § 718.205(c) by any one of the following criteria:

1. Competent medical evidence establishes that pneumoconiosis was the cause of the miner's death.

2. Evidence that pneumoconiosis was a substantially contributing cause or factor leading to the miner's death, or that death was caused by complications of pneumoconiosis.

[4] Claimant's pre-hearing statement contained two separate sections of evidence: evidence in the survivor's claim and the evidence from the previous living miner's claims. In *Church v. Kentland-Elkhorn Coal Corp.*, BRB Nos. 04-0617 BLA and 04-0617 BLA-A (Apr. 8, 2005) (unpub.), the Benefits Review Board (the "Board") found that inclusion of evidence from a prior living miner's claim is not automatically available in the survivor's claim and must be specifically designated as evidence by one of the parties to be considered in the survivor's claim. The Board also found that the evidence from a previous living miner's claim must meet the limitations imposed under § 725.414 before being considered in the survivor's claim. As Claimant's pre-hearing statement provided a listing of all of the evidence from the previous living miner's claims but did not specifically list which items of evidence should be considered in the survivor's claim, I will not consider any of the evidence from the prior living miner's claims in determining whether Claimant has met her burden in establishing the elements to entitlement.

3. Under § 718.304, the miner suffered from a chronic dust disease of the lung and chest X-ray evidence shows one or more large opacities (greater than 1 centimeter), biopsy or autopsy shows massive lesions in the lung, or other evidence (in accord with acceptable medical procedures) show a condition which could reasonably be expected to yield such large opacities or massive lesions.

Section 718.205(c)(5) provides that pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death. § 718.205(c)(5).

As noted above, the record contains no evidence of large opacities, massive legions, or any other condition which a physician has stated could be expected to result in these. Therefore, § 718.304 is inapplicable here.

The record contains the opinions of the following physicians.

Dr. Alex Presbitero Racadag performed a limited autopsy of the miner's lungs, and issued a report dated February 10, 2003. The physician noted that on the primary incision he noted bilateral basil pleural adhesions. Dr. Racadag's review of the miner's respiratory system showed that the pleural surfaces were predominately smooth and shiny, except for the bases which were pink-gray with extensive black mottling and bosselation. The physician found that the hilar lymph nodes were blackened but that the mucosa was smooth and there were no endobronchial lesions. Serial sectioning of both lungs showed similar changes. Dr. Racadag also found that the formalin-fixed cut surfaces were tan-brown in appearance with black coal macules located mostly in the upper lobes and that both lower lobes showed dark brown discoloration and congestion. The physician also provided a microscopic description of the 14 specimens taken during the autopsy. Dr. Racadag found that both upper lobes showed coal macules represented by subpleural, perivascular, and peribronchiolar aggregates of black pigmented histiocytes with mild fibrosis and focal emphsematous changes. The physician found that the lower lobes and lymph node also showed similar aggregates of pigmented histiocytes. However, in the lower lobes the histiocytes were smaller and without fibrosis while in the lymph nodes they only had minimal fibrosis. Dr. Racadag stated that the intra-alveolar pigmented histiocytes were also present in the specimens and that the blood vessels were congested, particularly in the lower lobes. The physician's final pathological diagnosis of the miner's respiratory system was simple coal worker's pneumoconiosis, bilateral basal pleural adhesions, and bilateral lower lobe congestion. Dr. Racadag also commented that he believed that the above listed diagnoses "probably contributed to patient's morbidity." DX 15.

Dr. Joshua A. Perper (Board-certified in anatomical, surgical, and forensic pathology) reviewed the miner's medical records and examined the autopsy slides, issuing a report dated November 22, 2004. The physician reviewed the death certificate, Dr. Racadag's autopsy report dated February 10, 2003, the accompanying 14 pathology slides, records from the miner's admissions to Logan General Hospital dated August 7, September 9, October 11, and November 28, 2002, records from Logan General Hospital's Ambulatory-Patient Clinic dated January 6, 2003, records of the Asthma and Allergy Center dated June 18, 1998, and the records from Family Health Care Associates, Inc. dated November 15, 2000 until August 12, 2002. Dr. Perper

also reviewed Dr. Rasmussen's report dated March 13, 1995, Dr. Velasco's report dated July 23, 1979, Dr. Iyer's office notes from 1991 until 2002, Dr. Bush's report dated June 12, 2003, Dr. Naeye's report dated June 1, 2003, Dr. Hippensteel's report dated March 23, 2004, Dr. Fino's report dated June 16, 2004, and Dr. Spagnolo's report dated August 1, 2004. The physician reviewed echocardiograms dated June 29, 2000, July 16, 2001, September 12 and November 14, 2002, electrocardiograms dated November 12, 1991, March 13, 1995, November 12, 14, and 28, 2002, and January 14, 2003, chest X-rays dated August 20, 1977, July 23, 1979, February 21, 1995, March 13, 1995, September 12 and December 2, 2002 and the multiple readings of the X-rays where applicable, arterial blood gas studies dated July 23, 1979, March 13, 1995, and November 28, 2002, pulmonary function tests dated July 23, 1979, April 10, 1985, January 6, 1994, February 21 and March 13, 1995, and July 24, 2002, and a CT scan dated January 9, 2003. Dr. Perper credited the miner with at least 35 years of coal mine employment and credited the miner with a negative smoking history, although he noted that there were discrepancies in the miner's smoking history as reported over time.

Dr. Perper opined that the miner's "simple pneumoconiosis and causally associated centrilobular pulmonary emphysema was a substantial contributory and a hastening factor of his death, both directly and indirectly, by precipitating or facilitating a fatal arrhythmia, on the background of his heart disease."[5] In coming to this conclusion, the physician relied on the autopsy slides which showed pneumoconiosis and "causally associated centrilobular emphysema." Dr. Perper stated that his review showed the miner had "[c]oal workers' pneumoconiosis macular, micronodular and focally interstitial, simple, mild to moderate, moderate to marked centrilobular emphysema, and marked sclerosis of the intra-pulmonary blood vessels that is consistent with pulmonary hypertension and cor pulmonale." The physician also relied on the "documented objective, combined obstructive/restrictive pulmonary defect and arterial blood gases indicative of hypoxemia," and the miner's medical history of episodes of arrhythmia and his increased susceptibility of arrhythmia due to his symmetric septal hypertrophy in concluding that pneumoconiosis was a significant contributing factor to the miner's death.

Dr. Perper opined that it was unlikely that non-Hodgkin's lymphoma was the primary or substantial cause of the miner's death as the CT scan performed on January 9, 2003, three weeks before the miner's death showed the "virtual disappearance of the abdominal lymphoma mass and lymphadenopathy" and the miner's last three medical visits on January 14, 16, and 30, 2003, showed that the miner's condition was stable with no changes regarding lymphadenopathy or visceral masses. Even though the physician opined that the non-Hodgkin's lymphoma was not the cause of the miner's death, Dr. Perper went on to conclude that "one cannot reasonabl[y] exclude the possibility that exposure to coal dust containing silica may be a primary or a contributory factor in the etiology of [the miner's] non-Hodgkin's lymphoma. . ." The physician based his opinion on "a number of studies [that] have showed [sic] that exposure to significant

[5] Dr. Perper's report also opined that the miner had pneumoconiosis and that it arose out of his coal mine employment. However, as Employer has already conceded those issues, my review of Dr. Perper's report will focus on his opinions regarding the cause of the miner's death and the role played, if any, by pneumoconiosis.

levels of silica can result in malignant lymphoma" and that his review of the autopsy slides showed the presence of birefringent silica in the miner's lungs.

Dr. Perper also criticized the reports of Drs. Bush, Fino, and Hippensteel. Dr. Perper opined that all of the other physicians "unreasonably downgraded the significance of [the miner's] pneumoconiotic process and causally associated centrilobular emphysema," dismissed any connection between exposure to mixed coal dust containing silica and the miner's lymphoma, and ignored the significance of the miner's January 9, 2003 CT scan and his last three medical visits on January 14, 16, and 30, 2003, discussed above. Dr. Perper also criticized Dr. Bush's report because he felt the physician "minimized the pathological findings of pneumoconiosis" found on the autopsy slides, downgraded the severity of the moderate to marked centrilobular emphysema, and failed to acknowledge it['s] relationship to occupational coal dust exposure and pneumoconiosis, and because the physician did not have access to the miner's substantial medical history. The physician criticized Dr. Fino's report for only mentioning the miner's subjective complaints as recorded in Dr. Rasmussen's 1995 report and criticizing Dr. Hippensteel's report for not even discussing the 1995 subjective complaints. Dr. Perper also criticized both Drs. Fino and Hippensteel's reports for denying that the miner had a "significant history of pulmonary symptomatology or impairment." CX 1.

Dr. Stephen T. Bush (Board-certified in anatomic and clinical pathology) reviewed the miner's autopsy and accompanying slides and issued a report dated June 12, 2003.[6] The physician reviewed the miner's death certificate, the autopsy report of February 2, 2003 and the accompanying 14 histologic slides. Dr. Bush also reviewed the answers to interrogatories which showed that the miner had a hernia repair in August 2000, was diagnosed with pneumonia, anemia and non-Hodgkin's lymphoma in November of 2002, and had heart problems in January 2003. The physician opined that pneumoconiosis "played no role in nor hastened the death" of the miner. In coming to that conclusion, Dr. Bush relied on his review of the histologic slides from the autopsy from which he opined that "less than 5 percent of the lung tissue [was] destroyed by the fibrotic reaction from coal worker's disease" and the miner had only mild centrilobular emphysema overall. The physician also stated that he disagreed with Dr. Racadag's comment that pneumoconiosis probably contributed to the miner's morbidity because the extent of the disease in the miner's lungs was so limited it could not have contributed to any respiratory impairment. Dr. Bush did opine that the miner was totally disabled prior to death due to his malignant non-Hodgkin's lymphoma.

[6] At the hearing Claimant objected to the admission of Dr. Bush's report stating that it exceeded the evidentiary limitations. As the Employer had submitted the reports of Drs. Fino and Hippensteel, who reviewed the entire medical record and issued opinions regarding the cause of the miner's death, and the report of Dr. Bush who reviewed the miner's medical history and autopsy slides and issued a report regarding the cause of the miner's death, Claimant argued that Dr. Bush's report exceeded the evidentiary limitations. Employer's counsel argued that Dr. Bush's report did not exceed the limitation as he reviewed the slides and the medical data that accompanied the slides so he could provide a complete report. At the hearing I ruled that my consideration of Dr. Bush's report would be limited to the purpose for which it was introduced. Tr. at 11-13.

Dr. Bush issued a supplemental report on December 18, 2004, after reviewing Dr. Perper's report. Dr. Bush criticized Dr. Perper's report for a number of reasons. First, although Dr. Perper stated there was "documented objective, combined obstructive/restrictive pulmonary defect and arterial blood gases indicative of hypoxemia," Dr. Bush found that the physician did not provide the sources of the information, the context of any other disease or treatments that may have been associated with the finding, and questioned the validity of Dr. Perper's statement considering the miner's treating physicians did not diagnosis or treat the miner for obstructive/restrictive pulmonary defect and hypoxemia. Additionally, Dr. Bush criticized Dr. Perper's finding that the miner's death involved pulmonary insufficiency caused in part by pneumoconiotic lesions and emphysema as it was inconsistent with Dr. Perper's own medical review of the miner's final months of life which showed that the miner was not diagnosed with pulmonary insufficiency by his treating physicians. Dr. Bush also disagreed with Dr. Perper's assertion that silica contained in the mine's coal dust caused or contributed to the development of the miner's malignant non-Hodgkin's lymphoma. Dr. Bush stated that the references provided by Dr. Perper only vaguely suggest a causal relationship between the two and that there is no evidence in the histologic slides or work history that showed the miner was exposed to high silica dust levels. Lastly, Dr. Bush found Dr. Perper's conclusion that a fatal arrhythmia hastened by pulmonary disease was the cause of the miner's death to be arbitrary and erroneous as there was an absence of significant pulmonary disease in the miner's medical history. Dr. Bush opined that the miner's death was the result of complications from the treatment of the miner's malignant lymphoma and that the miner's pneumoconiosis and coal dust exposure did not contribute to or hasten the miner's death as he "would have died at the same time and in the same manner of the complications of malignant lymphoma if he had never been exposed to the pulmonary hazards of coal mining employment." EX 11.

Dr. Bush also testified in a deposition on February 2, 2005. The physician opined that the miner's pneumoconiosis was "mild in degree and extent" as the histologic slides only showed small coal workers' micronodules. Dr. Bush also estimated that only about five percent of the all the miner's lung tissue was affected by the pneumoconiotic lesions. EX 14 at 13-14. The physician stated that centrilobular emphysema was present in the miner but was not significant in degree. EX 14 at 16-18. Dr. Bush also opined that the miner's death was due to complications caused by his malignant lymphoma and its treatment through chemotherapy which caused the miner to become debilitated. EX 14 at 21. The physician stated he disagreed with Dr. Racadag's comment that pneumoconiosis contributed to the miner's morbidity considering the "very limited extent" of the pneumoconiosis and that the disease would have only had a "silent presence" because it would not have affected the miner's pulmonary function in any significant way. EX 14 at 22. Dr. Bush also stated that he disagreed with Dr. Perper's conclusions regarding the cause of the miner's death. Specifically, Dr. Bush found that the miner's medical history did not support Dr. Perper's finding of a chronic lung disease. Dr. Bush did admit that the miner was receiving supplemental oxygen during a hospitalization in November of 2002 but that it was in response to a diagnosis for bilateral pneumonia linked to the miner's lymphoma and chemotherapy and that the hypoxemia did not continue in subsequent hospitalizations and examinations. EX 14 at 26-27.

Dr. Bush stated that the miner's "management and his diagnoses were related to the lymphoma and the treatment he received from lymphoma. The record clearly describes an individual with this malignant lymphoma who became more and more debilitated and that is weakened, by the malignant disease and probably from the treatments to slow down the malignant disease to the point where he was unable to survive." EX 14 at 24-25. Dr. Bush also disagreed with Dr. Perper's comments regarding the connection between silica and malignant lymphoma. Dr. Bush distinguished the articles relied on by Dr. Perper finding that the studies could not be related to the lymphoma found in the miner. EX 14 at 28-29. Further, Dr. Bush stated that the miner's lungs did not contain an unusual amount of silica and that the process normally associated with the pathology induced by silica, collagenous round nodule scarring, was not present in the miner. EX 14 at 30-31. Additionally, Dr. Bush disagreed with Dr. Perper's opinion that arrhythmia caused the miner's death because the miner's pulmonary disease was too small in amount to have caused such a reaction. EX 14 at 31-32. Dr. Bush concluded his deposition by stating that there was "nothing in the histologic slides, and the autopsy report or in the medical records that could, in any way, link coal mine dust exposure to the disease and death suffered by [the miner]." EX 32-33.

Dr. Kirk E. Hippensteel (Board-certified in internal medicine and pulmonary disease) reviewed the miner's medical records and issued a report dated March 23, 2004. The physician credited the miner with 43.5 years of coal mine employment and considered a smoking history of four cigars a day from 1952 until 1980. Dr. Hippensteel reviewed the miner's claims for benefits dated May 16, 1973 and January 15, 1995, and the survivor's claim dated March 11, 2003. The physician also reviewed chest X-rays dated June 29, 1973 read by Drs. Jacobson and Pelaez, March 13, 1995 read by Drs. Patel and Gaziano, a pulmonary function study dated February 21, 1995, an arterial blood gas study dated February 8, 2000, echocardiograms dated June 29, 2000, July 26, 2001, September 12 and November 14, 2002, and a CT scan report dated January 9, 2003. Dr. Hippensteel reviewed Dr. Velasco's report dated July 23, 1979, Dr. Iyer's progress notes dated November 12, 1991 until January 14, 2003, records from Logan General Hospital dated August 27, September 9, October 11, and November 28, 2002, oncology notes from January 2003, Dr. Bush's report dated June 12, 2003, the miner's death certificate, and the autopsy report dated February 10, 2003. The physician concluded:

> [the miner] had pathologic evidence of simple coal workers' pneumoconiosis at death that was not associated with any significant pulmonary impairment from ventilatory or gas exchange standpoint during his life. Since his coal dust deposition created no change in function, it cannot be considered a process that hastened his death, which was caused by his stage IV, non-Hodgkin's lymphoma. There is no association between lymphoma and coal mine dust exposure. The findings in this case show with a reasonable degree of medical certainty that this man would have died from the same problem at the same time had he never inhaled coal mine dust.

EX 3.

Dr. Hippensteel issued a supplemental report on January 18, 2005, after reviewing Dr. Perper's report. The physician criticized Dr. Perper for ignoring the objective pulmonary findings and concentrating on the miner's subjective symptoms as "symptomatology is nonspecific as to cause and is a poor indicator of functional status from a pulmonary basis. . ." Dr. Hippensteel also criticized Dr. Perper's statements regarding exposure to silica and lymphoma as the medical literature has not shown that a coal miner's exposure to silica has any effect on future cancer risk. The physician also stated that objective evidence in the miner's medical records did not support Dr. Perper's comment that the histologic slides showed marked sclerosis of intrapulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale. Specifically, Dr. Hippensteel stated that the main findings on miner's echocardiography was subaortic stenosis with idiopathic septal hypertrophy of his heart with only one comment on June 29, 2000, regarding a mildly elevated pulmonary artery pressure, "which is associated with his heart abnormalities and not be referable to lung impairment since this man did not have lung impairment causing heart disease, which is needed to make a diagnosis of cor pulmonale." The physician also criticized Dr. Perper's assessment of the severity of the miner's pneumoconiosis as a causative factor in hastening his death as the objective pulmonary function tests did not support such a conclusion. Dr. Hippensteel reiterated his opinion that although the miner had simple pneumoconiosis it "was not associated with any pulmonary impairment and did not hasten his death in any way." EX 13.

Dr. Hippensteel also testified in a deposition on February 14, 2005. The physician stated that he had reviewed Drs. Bush and Fino's reports dated December 29, 2004 and December 18, 2004, respectively, before the deposition. EX 13 at 9-10. Dr. Hippensteel pointed out that the miner's pulmonary function studies and arterial blood gas studies were normal and did not even show minimal obstruction. EX 13 at 12-14. The physician stated the miner had developed stage IV non-Hodgkin's lymphoma, which means the disease had spread throughout his body, and that was what caused his death. EX 13 at 14. Dr. Hippensteel also discussed his criticisms of Dr. Perper's findings. First the physician disagreed with Dr. Perper's association of silica in coal mine dust and the miner's non-Hodgkin's lymphoma. Dr. Hippensteel stated that the medical literature has not linked coal mine dust exposure, even if it contains silica, with any increased incidence of cancer, including non-Hodgkin's lymphoma. EX 13 at 14. The physician also stated that the miner did not develop silica granulomas preceding the appearance of his lymphoma, which would have been necessary for there to have been an association between the two. Dr. Hippensteel also disagreed with Dr. Perper's finding of pulmonary hypertension and cor pulmonale. The physician stated that the miner had one specific objective echocardiography finding of asymmetric septal hypertrophy with possible associated outflow tract obstruction but it was a transient elevation in pulmonary blood pressure that was related to his heart problem and not any pulmonary disease. As the one instance of outflow tract obstruction was not a lung derived heart effect, but a heart derived pulmonary effect, there was no cor pulmonale. EX 13 at 18-20. Dr. Hippensteel reiterated his opinion that the miner died of stage IV non-Hodgkin's lymphoma and that pneumoconiosis did not cause, contribute to, or hasten the miner's death. EX 13 at 20-21.

Dr. Gregory J. Fino (Board-certified in internal medicine and pulmonary disease) reviewed the miner's medical records and issued a report dated June 16, 2004. The physician credited the miner with 43.5 years of coal mine employment. Dr. Fino reviewed the survivor's

claim form dated March 11, 2003, chest X-rays dated June 29, 1973 interpreted by Dr. Jacobson, July 23, 1979 interpreted by Drs. Elmer and Subramanian, March 13, 1995 interpreted by Drs. Patel and Graziano, and December 2, 2002, pulmonary function studies dated February 21, 1995, July 23, 1979, March 13, 1995, and February 8, 2000, an arterial blood gas dated February 8, 2000, echocardiograms dated June 29, 2000, July 16, 2001, September 12 and November 14, 2002, and a CT scan report dated January 9, 2003. The physician also relied on Dr. Velasco's report dated July 23, 1979, Dr. Rasmussen's report dated March 13, 1995, Dr. Iyer's progress notes dated from September 9, 2002 until January 14, 2003, Hematology Oncology Clinical notes dated from September 9, 2002 until January 20, 2003, records from admission to Logan General Hospital dated November 28, 2002, Dr. Bush's report dated June 12, 2003, the autopsy report dated February 1, 2003, and the miner's death certificate. Dr. Fino stated that the pathologic evidence showed that the miner had pneumoconiosis. The physician also admitted that the miner had an arterial blood gas study in 1979 that showed hypoxemia, however, subsequent arterial blood gas studies were normal and other objective evidence did not show any respiratory impairment from any type of intrinsic lung disease prior to his death. Dr. Fino opined that the miner was disabled by heart disease and non-Hodgkin's lymphoma, both of which did not have any causal association to his coal mine employment, and that the miner died as a result of his lymphoma and malnutrition. EX 5.

Dr. Fino issued a supplemental report on December 29, 2004, after reviewing Dr. Perper's report. The physician agreed with Dr. Perper that the pathology review did prove the presence of pneumoconiosis and emphysema. However, Dr. Fino stated that pathology is not useful in assessing impairment and that objective testing must be relied upon in assessing impairment. The physician also disagreed with Dr. Perper's clinical diagnosis of chronic obstructive pulmonary disease as there was no objective verification through pulmonary function tests that supported the diagnosis. Dr. Fino also found there was a lack of objective evidence to support Dr. Perper's opinion regarding the presence of cor pulmonale. The physician conceded that some of the echocardiograms showed some pulmonary hypertension, however, opined that the "variable pulmonary hypertension was clearly related to [the miner's] significant heart problems which included subaortic stenosis and outflow obstruction." Further, Dr. Fino also stated there was "no evidence of a lung condition resulting in significant impairment to affect the right ventricle and the pulmonary pressures." The physician opined that the miner "died as a result of non-pulmonary issues including lymphoma and cardiac disease. It is unreasonable to implicate any type of lung disease as a participating factor in his death." EX 12.

Discussion of Medical Opinion Evidence

Dr. Racadag performed the autopsy on the miner and concluded that the miner had pneumoconiosis, bilateral basal pleural adhesions, and bilateral lower lobe congestion which "probably contributed" to the miner's death. As autopsy evidence is the most reliable evidence of the existence of pneumoconiosis and the issue has already been conceded by Employer, I credit Dr. Racadag's opinion regarding the presence of pneumoconiosis. However, I find Dr. Racadag's comment regarding the conditions contributing to the miner's death troubling. First, the miner's autopsy was limited to the lungs to ascertain the presence of pneumoconiosis. This is significant considering that a potential cause of the miner's demise could have been his abdominal non-Hodgkin's lymphoma, effects of his chemotherapy, and cardiac disease. Second,

Dr. Racadag's comment contains the qualifier "probably." A medical opinion that is unclear or equivocal is entitled to little or no weight. Justice v. Island Creek Coal Co., 11 B.L.R. 1-91 (1988); Parsons v. Black Diamond Coal Co., 7 B.L.R. 1-236 (1984). Further, his conclusion that it "probably" contributed to the miner's demise was conclusory, as the doctor failed to explain how the evidence collected at the autopsy correlated with his conclusion. Therefore, I find that Dr. Racadag's opinion that the miner's death was due to pneumoconiosis is entitled to little weight.

Dr. Perper opined that both pneumoconiosis and emphysema substantially contributed to the miner's death. In coming to this conclusion, the physician relied on objective medical testing, the miner's echocardiogram, and his review of the pathology slides. Specifically, Dr. Perper found that the miner had mild to moderate pneumoconiosis and moderate to marked centrilobular emphysema based on the miner's symptomology which included dyspnea on extertion, shortness of breath, and productive cough. However, all of the miner's pulmonary function tests and all but one of the miner's arterial blood gases showed normal pulmonary function. Beyond the pathologic presence of the disease and the miner's symptomology, Dr. Perper fails to reconcile the normal objective testing results with his diagnosis of obstructive and restrictive pulmonary disease. Dr. Perper found that the miner's pneumoconiosis and emphysema were substantial contributing factors in the miner's death "both directly and indirectly by precipitating or facilitating a fatal arrhythmia, on the background of his heart disease." CX 1. However, the miner's medical records do not show that pulmonary insufficiency was diagnosed during the last months of the miner's life except for the one instance in which the miner experienced bilateral pneumonia, which has been attributed to his chemotherapy. Additionally, the miner's medical records did not show that any of the miner's treating physicians, including his cardiologist, expressed a concern about arrhythmias or the interplay between the miner's cardiac and pulmonary conditions nor did they diagnose cor pulmonale. The medical records also fail to document the existence of a chronic pulmonary condition.[7]

Dr. Perper also concluded that the miner's lymphoma and chemotherapy treatment was not a substantial contributing factor to the miner's death because the January 9, 2003 CT scan showed that the lymphoma had virtually disappeared and the miner's last three medical visits on January 14, 16, and 30, 2003, showed that the miner's condition was stable regarding lymphadenopathy or visceral masses. However, from a review of the miner's medical records, it was not until the miner was diagnosed with lymphoma and treated with chemotherapy did he experience a drastic decline in his health. Further, even though Dr. Perper did not find the lymphoma to be a contributing cause to the miner's death, the physician found an association between the silica found in the miner's lungs and his abdominal lymphoma. In support of this association, Dr. Perper referred to a number of academic articles. However, Dr. Perper very briefly referred to the general conclusions of those medical publications and did not provide those articles as attachments to his report. Moreover, Dr. Bush provided more thorough summaries of the articles cited by Dr. Perper. These more thorough summaries and Dr. Bush's

[7] Dr. Perper referred in his report to records from the Asthma and Allergy Center and Family Health Care Associates which he stated supported his finding of the miner's chronic pulmonary disease. However, as the records were not placed into evidence, I am unable to assess whether they do or do not support Dr. Perper's conclusions.

comments regarding their relevance places Dr. Perper's reliance on the articles into question. EX 14 at 27-29. For all of the reasons discussed above, I find that Dr. Perper's opinion that the miner's death was due to pneumoconiosis is entitled to no weight.

I find that the opinions of Drs. Bush, Hippensteel, and Fino are well-reasoned and well-documented. A documented opinion is one that sets forth clinical findings, observations, facts and other data upon which the physician based the diagnosis and conclusions. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987); Hess v. Clinchfield Coal Co., 7 B.L.R. 1-295 (1984). An opinion is reasoned when the underlying data and documentation are adequate to support the physician's conclusions. Fields, supra. All three physicians reviewed the medical records supplied them, considered the results from objective medical testing, and considered the other medical evidence of record in reaching their conclusions that the miner's death was due to complications from his non-Hodgkin's lymphoma and chemotherapy and that pneumoconiosis neither hastened, contributed to, or caused the miner's death. I accord more weight to the opinions of Drs. Hippensteel and Fino as they were able to review all of the miner's medical records. I place less weight on Dr. Bush's opinion as his opinion was limited to a review of the histological slides and suffers from the same deficiencies as Dr. Racadag's opinion with regard to the limited nature of the autopsy performed. Consequently, I find that the weight of the medical opinion evidence does not establish that the miner's death was due to pneumoconiosis.

I note that the medical treatment records show that the miner was treated for non-Hodgkin's lymphoma from September 2002 until his death in early 2003. However, these records also show that the miner was not treated for either pneumoconiosis or emphysema shortly before his death. As such, these records do not support a finding that the miner died due to pneumoconiosis.

Finally, the miner's death certificate reports that the miner died due to cardiorespiratory failure and non-Hodgkin's lymphoma, with malnutrition listed as an "other significant condition." Consequently, I find that the miner's death certificate does not establish that the miner's death was due to pneumoconiosis.

Based on the above, I find that Claimant has failed to establish that the miner's death was due to pneumoconiosis, pursuant to § 718.205(c).

ORDER

The survivor's claim of BETTY L. FIELDS for benefits under the Act is DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with the Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must be served on Donald S. Shire, Associate Solicitor, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.